

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 3 — 0 0 2

2. STATE:

Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

February 18, 2003

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.120 and 440.230(d)

7. FEDERAL BUDGET IMPACT:

a. FFY 2003 \$ (\$2,545,785)

b. FFY 2004 \$ (\$4,435,997)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1A, page 5 ee

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

See

Attachment 3.1A, page 5 ea & 5 eb

10. SUBJECT OF AMENDMENT:

Prior Authorization of drugs for treatment of erectile dysfunction, OxyContin, and cyclooxygenase-2 (Cox 2) selective non-steroidal anti-inflammatory drugs (NSAIDS)

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Review and approval authority has been delegated to the Secretary of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Estelle B. Richman

13. TYPED NAME:

Estelle Richman

14. TITLE:

Secretary of Public Welfare

15. DATE SUBMITTED:

16. RETURN TO:

Commonwealth of Pennsylvania
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

5/15/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

2/18/2003

20. SIGNATURE OF REGIONAL OFFICIAL:

Mary T. Morsorley

21. TYPED NAME:

MARY T. MCSORLEY

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
12. <u>Prescribed Drugs, Dentures, and Prosthetic Devices, and Eyeglasses</u>	
12.a. Prescribed Drugs (continued)	<u>Limitations on Payment</u> Prior authorization is required for the following: 1. Multisource brand name drugs identified by the state agency as having A-rated generics available for substitution except for those brand name drugs whose net cost after rebate is less than the A-rated generic cost. 2. Anti-ulcer drugs identified by the state agency in the following situations: (i) Continued treatment at the acute level dosage used in excess of 90 days for any condition. (ii) Concurrent use with another anti-ulcer drug at any dosage level. (iii) A change from one ulcer drug to another during the initial 90 day acute stage. (iv) New prescriptions issued after the 90-day acute stage for continued use at the acute dosage level. 3. Drugs indicated for the treatment of Erectile Dysfunction. 4. Prescriptions for OxyContin® under the following condition: (i) Prescriptions that exceed doses of greater than three (3) tablets per day of any single strength of OxyContin®. (ii) Prescriptions for more than two (2) different strengths of OxyContin® that are taken concurrently.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
12. <u>Prescribed Drugs, Dentures, and Prosthetic Devices, and Eyeglasses</u>	
12.a. Prescribed Drugs (continued)	<u>Limitations on Payment</u> 5. Prescriptions for cyclooxygenase-2 (COX-2) selective non-steroidal anti-inflammatory drugs (NSAIDs) under the following condition: (i) The recipient is taking another NSAID, or (ii) The prescribed dosage is higher than the dosage recommended by the United States Food and Drug Administration, or (iii) The recipient is under 70 years of age and is not taking an anticoagulant.